EMS ADVISORY COUNCIL MEDICAL CARE COMMITTEE FINAL REPORT
STRATEGIC PLAN COMPLETED JANUARY 2013
Patricia M. Byers, MD, FACS, Chair

GOAL 1: Leadership and membership

Seven face-to-face meetings of the Medical Care Committee were held in conjunction with the EMSAC constituency group meetings from October 6, 2010 to October 2, 2012. Attendance has been excellent with participation from fire rescue and ambulance services, county EMS agencies, DOH EMS, trauma centers, EMLRC, FCEP, trauma agencies, fire districts, private hospital corporations, EMSC, flight nurses, universities, and life guards.

GOAL 6: System Effectiveness

Strategy 6.1: Dispatch Effectiveness

In July 2010 legislation passed that required mandatory certification of all Public Safety Telecommunicators following 132 hours of specified education with a certifying exam that became available in October 2010 and was mandatory by October 2012.

There was a presentation of a trial study by the CDC and BMW that is going on in Florida where PSAPs would receive direct communication electronically or verbally regarding crash severity. The ability of this to decrease response time was discussed and results will be presented at a later date.

We discussed the importance of utilizing NAACS standards for air medical dispatch.

There is a movement to develop POLST – Physician Ordering Life-sustaining Treatment – in Florida. By informing patients and families regarding end of life decisions, inappropriate calls to dispatch for terminal patients may go down. Interested Medical Care Committee members are on the mailing list for POLST developments.

Strategy 6.2: EMS Response Times

Discussed with Steve McCoy (EMSTARS) and definition developed: time to dispatch call to EMS to patient contact. With >3million runs in 115 agencies, median response time was 6 minutes, 21 seconds. This can be starting benchmark.

Strategy 6.3: Offload times

This could not be determined due to a lack of EMSTARS consistent data. Instead, we worked with Access to Care to push for propagation of EM Systems to create more efficiency in system.

Strategy 6.4: Outcome measures

-Cardiac-Dr Nelson reported results of Data Committee regarding chest pain runs: After review of 37,000 runs for chest pain, aspirin was given within 10 minutes as a mean value

-Airway-Dr. Nelson reported that there is poor documentation in EMSTARS regarding use of capnography following intubation. There was the discussion that this is most likely data element and documentation problem.

Strategy 6.5 Improvement in EMS Systems

Sal Sylvestre has done a study in this area

-Broward County Stroke Study was presented: 155 patient w stroke symptoms

39% had stroke alert called and had stroke

41% called w no stroke/tia

19% (30 pts) stroke alert not called and 18 pts had strokes

-Patients refusing transport: all agencies have different protocols re this

POLST is being developed to aid in scene decisions regarding terminal patients. EMS is getting involved as 401 DNR form is in statute and if this is replaced, clear DNR must be available on POLST form for pre-hospital responders.

There was quite a bit of discussion regarding tourniquets and the ability to stop life-threatening limb hemorrhage without risk of limb loss, when used properly. The EMS Advisory website has a draf t protocol that was developed, but never approved due to proprietary nature of recommendations. Mr. Soto gave a presentation on the principles of tourniquet use and at another meeting the principles outlined in the Denver Tourniquet Protocol were discussed. It was ascertained that cost, information and training were barriers to implementation, as many Florida agencies do not have tourniquet protocols. It was felt that a position paper on guidelines of protocol development was all that was needed as Medical Directors would develop their own specific protocols based on their systems.

Strategy 6.6: Quality Management and Quality Improvement in EMS System

This goal and an attempt of standardization of these measures is being considered by the Quality Managers.

Strategy 6.7: Development of EMS Agency Performance Targets

The Data Committee is investigating this and has recorded two potential benchmarks above regarding response times and aspirin for chest pain. The development of benchmarks for intubation and capnography are being developed by the data committee and will be collected more accurately in the new version of EMSTARS data.

Strategy 6.8: To provide effective injury prevention, rescue and pre-hospital emergency care to improve safety of bathing places with the lead being the USLA. Currently the Lifeguard group is housed in FACEMS. The measure of the number of coastal lifeguard agencies operating in Florida has been catalogued, along with which are USLA certified. The other measure of identifying the % of Florida bathing places that are lifeguard protected will be difficult as it is hard to define bathing places in areas with sprawling coastline. Draft legislation for improving regulation and certifying lifeguard agencies was proposed and will be presented to Legislative Committee.

Lifeguard agencies	Public (%)	Dept Fire/Fire R/Emerg svcs	EMT cert Required (%)	MOU Med Director	USLA Certified
48	45 (94%)	15 (31%)	23 (48%)	32 (23%)	33 (69%)

GOAL 9: Increase access to care by improving patient, responder and public safety.
Strategy 9.1: Determine medical error rate in Florida's EMS Systems

Dr. Nelson felt that the failure to recognize improper endotracheal intubation would be an important measure to evaluate to meet this goal. EMRC was going to review the use of capnography which is the current best practice.